AZ Medicaid Technical Consortium Meeting

April 21, 2004
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

(Based on sign-in sheets)

ADHS	*Mike Upchurch*	*Art Schenkman*
Jeff Bemis	**APIPA**	**Maricopa**
CJ Major	*Lucy Markov*	*Bree Reiser*
Ramkumar Manakal	*Charles Renew*	**Pinal LTC**
Luis Vasquez	*Sharon Zamora*	*Susan Murphy*
AHCCCS	**Care 1st Arizona**	**PHP**
Peggy Brown	*Bill Hobbs*	*Greg Lucas*
Deborah Burrell	*Herb Woo*	*JoAnn Ward*
Barbara Butler	**DES**	**PHS**
Deborah Copeland	*Marcella Gonzalez*	*Mark Hart*
Michelle Dillon	*Major William*	**UFC**
Rebecca Fields	*Nicole Yarborough*	*Kathy Steiner*
Patti Goodwin	**Evercare Select**	**United Drugs**
Chris Herrick	*Vicki Johnson*	*Rand Skelton*
Ester Hunt	**Healthchoice AZ**	**Verizon**
Dennis Koch	*Paul Benson*	*Larry Bryce*
MaryKay McDaniel	*Robert Tibbs*	**Yavapai**
John Murray	*Mike Uchrin*	*Dave Soderberg*
John Nystedt	**HCSD**	
Brent Ratteree	*Michael Wells*	
Marna Richmond	**IHS**	
Lydia Ruiz	*Charolett Melcher*	
Diane Sanders	**MCP & Schaller Anderson**	
Marsha Solomon	*Maria Contreras*	
Carrie Stamos	*Walter Janzen*	
Linda Stubblefield	*Anne Romer*	

1. Welcome (MaryKay McDaniel)

Welcome everyone. We have Pat Payton from CMS, NPI expert, with us today via telephone conference.

2. NPI Teleconference Presentation (Pat Payton)

Hello, I am Pat Payton from the Office of HIPAA Standards and CMS. I am happy, although I wish I could be out there, to talk to you about the NPI. I think you all have the slides that I will be talking from.

Slide I

On January 23, 2004, we did publish the Final Rule that adopted the National Provider Identifier (NPI) as a standard unique health identifier for healthcare providers. We adopted this standard for use in standard transactions. Any entity that meets a regulatory definition of healthcare provider, that is the definition at 160.103, is eligible for an NPI. This means that a healthcare provider who is not a covered entity is eligible for an NPI. Of course, as well as providers that are covered entities. Being assigned an NPI does not make a non-covered provider a covered provider. They would still have to transmit data electronically to be a covered provider. Entities who never render healthcare do not meet the definition of a healthcare provider. Some health plans, including some Medicaid states, reimburse for services that are not healthcare such as taxi services, carpentry services, etc. Because these services are not healthcare, and the entities that furnish them are not healthcare providers, these entities are not eligible for NPIs. The NPI is meant to be a lasting identifier. It doesn't have an expiration date. It won't change over time. If a physician, for example, retires, his or her NPI would be deactivated, and it would never be assigned to any other provider. If the physician decides to return to his practice, the deactivated NPI would be re-activated, and the National Provider System (NPS) would track these actions.

Slide 2

The Final Rule is not effective until May 23, 2005, which of course, is 16 months after the publication date. We have this long period of time between the publication date and the effective date so that we can finish the development of the NPS. That is the system that is going to uniquely identify a provider and assign it its NPI. After that, we need to test the system; it is going to have a lot of activity on it around the effective date. The compliance dates are May 23, 2007, for all covered entities except small health plans. Small health plans have until May 23, 2008. Once the NPI is implemented, the healthcare provider with an NPI will use its NPI, and only its NPI, to identify itself in standard transactions. In X12 transactions, a provider will use its NPI as its primary identifier and will not be required to report any other identifier to identify itself. As far as we are concerned, the only exception to this would be where it need to report a tax identifying number. The NPI was not meant to replace tax numbers.

Slide 3

Use of the NPI will simplify the HIPAA transactions by making them more efficient, which will save money for everyone in the long run. It will replace the use of legacy identifiers; these are basically the ones that a health plan has assigned to a provider over the years. Billing and Pay To providers may still need to report their taxpayer identifying numbers for tax purposes as required by the Implementation Guide. The NPI does not convey any special privileges to a provider that has one. It will not guarantee that a provider will be reimbursed by a health plan. It will not enroll a provider in a health plan. The assignment of an NPI and the enrollment in a health plan are two different activities conducted for different purposes by different entities. Health plans will have to continue to carry out their provider enrollment functions. Having an NPI, as I said before, will not make a provider a covered entity, and having an NPI will not require the provider to begin conducting transactions electronically if it doesn't all ready do so.

Slide 4

Probably everyone knows by now that the NPI is a 10 position all numeric identifier. Commenters on the proposed rules preferred this format to what we had proposed which was an 8 position alphanumeric number. The NPI has a check-digit in the 10th position, which will be helpful in detecting keying errors. You won't be able to look at an NPI and be able to tell anything about the provider that it identifies. This is because the NPI has no embedded intelligence in it concerning the provider. If we were to have included such intelligence, then the NPI would have to change every time that information changed, and that would not be very good criteria for a National Identifier. The NPI is compatible for with the health insurance card issuer standard which means that the NPI could be used to identify the provider as the issuer of a health insurance card if that need comes up at some point in the future.

Slide 5

As I mentioned earlier, NPIs are available to entities that meet a regulatory definition of a healthcare provider. We also do employ the subpart concept in being able to assign NPIs.

Slide 6

I will try to explain the "subpart" concept. A covered entity is a legal entity. A covered provider is, therefore, a legal entity. This is indicated in the legislation, and it is explained somewhat in the Privacy Rule. The subpart concept applies only to providers who are organizations; it doesn't apply to providers who are individuals like doctors and dentists. Not all organization providers are legal entities. Many times they are part or subparts, if you will, of larger organization providers who are legal entities. For example, a hospital dialysis unit furnishes healthcare and is part of the hospital. The dialysis unit may not itself be a legal entity, but the hospital is. The dialysis unit might bill health plans for the services it provides, and might even do this electronically. If it did all that, of course, it would be a covered entity if only it were also a legal entity. But the dialysis unit does need an NPI. So in this case the hospital, which is the covered entity, would apply for an NPI for the dialysis unit or the hospital would instruct the dialysis unit to apply for its own NPI. We have no preference on which way the hospital would decide it would want to do this. These subparts may or may not correlate to healthcare components of hybrid entities or to organize healthcare arrangements. Those are concepts explained and used to implement the Privacy and Security Rules. They are not needed to implement the NPI rule. Instead, we employ the subpart concept.

Slide 7

A covered organization provider, therefore, needs to look at itself and determine if it has subparts, and whether or not any of those subparts need NPIs. If a covered organization provider has subparts that are assigned NPIs, that covered organization provider is responsible for the subparts compliance with the Final Rule. For example, if a complaint is filed against the subpart, say that dialysis unit that I talked about, the parent covered entity, which would be the hospital, is ultimately responsible, and that is who the complaint would actually be against.

Slide 8

Providers will obtain their NPIs by completing an application. We expect applications to be able to be filed over the Internet or on paper. The NPS will electronically process the applications, certain data will be edited, reformatted and validated, and the NPS will also run a duplicate check to ensure that the provider applying for the NPI doesn't all ready have one. If the application is submitted properly containing all the necessary information and the NPS verifies that the provider does not all ready have an NPI, the NPI will be generated, and the provider will receive notification of its NPI.

Slide 9

Only a provider that can be uniquely identified will be assigned an NPI. The information collected on the application will be used for this unique identification. HIPAA legislation did not include any special funding mechanism; we are not able to charge a provider or anybody else for NPIs. We knew we had to collect the minimum of information necessary to uniquely identify a provider. We also knew that the more data that we collected, the more expensive the process would be. We will be collecting some of the same information from those organizations an individuals, who are the two categories of providers, but other information is dependent on whether the provider is an individual or an organization. Some of the data that we will be collecting on the application are repeating data elements. This means we will capture as much information as the provider chooses to furnish when it completes its application. In the NPS, providers are categorized as either individuals or organizations. Obviously, individuals are physicians and other practitioners, pharmacists, etc. Organizations are hospital laboratories, group practices, hospitals, and so on. A group practice is an organization provider, but each of those members are individuals. There is no category in the NPS called "groups". We had considered having a category called "groups", but all the information we would collect to uniquely identify them is the same that we would collect to uniquely identify an organization. We did decide not to capture the fact that a certain person is a member of a certain group because it is expensive to do so, it really doesn't help to uniquely identify the person, and all the health plans basically have to capture and maintain that information anyway. So they do it, and we don't. We also don't link individual healthcare providers with any groups of which they are members. The data on the application is either required, situational or optional.

Slide 10

This information is in the Final Rule, but I thought I would include it anyway in these slides. For providers who are individuals, we are requiring the name, gender, date, state and country of birth, address, phone number, Taxonomy Code, and the name and telephone number of a contact person. With respect to address, we will be collecting the mailing address and one practice location address. The Taxonomy Code is a repeating data element, so if the provider wants to describe itself with more than one Taxonomy Code, it would be able to do, and the NPS will capture all of the information. Situational data for individuals include the license number and state or multiple license numbers and states. They are dependent to some degree on the Taxonomy Code selected because if somebody is a medical doctor, they would need a license. Optional data for providers who are individuals include the Social Security number or the Individual Taxpayer Identification Number (ITIN), which is issued to people who are not eligible for Social Security numbers, the name prefixes and suffixes, such as Mr. or Mrs. and Junior and Senior, other names such as the maiden name or a previously used professional name, credentials such as MD, and other identifiers. Other identifiers include but are not limited to the legacy identifiers. This information, if providers report it, will help uniquely identify them and will aid other covered entities in matching providers in the NPS to the providers in their files. We certainly encourage providers to fill in all those other numbers that they have when they fill out their NPI application.

Slide 11

For providers who are organizations, we will capture as required data the name, address (again one mailing address and one practice location address), telephone number, Taxonomy Code or codes, an authorized officials name and telephone number, and a contact persons name and telephone number. This authorized official is the person at the organization provider who gives permission for the application to be and submitted. We don't collect this for individuals because we presume the individual is getting authorization. Situational data for organizations are the Employer Identification Number (EIN) defined by the IRS, and the license numbers and states that issued them. Again, if the provider furnishes the Taxonomy Code, and it is one for which a

license is required, the provider will be required to furnish the license number and state. There really aren't very many Taxonomy Codes where we know the license is required by every state. It doesn't quite carry the weight that we thought it would initially carry. Optional data for organizations include any other names, such as a "doing business as" name, and any other identifiers; again, the legacy identifiers or any other numbers that these providers use today. This will help ensure unique identification.

Slide 12

The Final Rule establishes a NPS and its functions. It is being developed under a contract with CMS within our Office of Financial Management. The NPS will receive and process the applications, it will assign one NPI to a provider or to a subpart, it will store information captured from the applications. We will keep that information current, because it will be updated whenever providers send us updates, which they are required to do within 30 days of any change in their information. The NPS will also generate various reports and statistics and will disseminate data as explained in our System of Records Notice that was published in the Federal Register in July of 1998. I do not know how many people have read that notice. It probably needs to have a few information updates, but basically it states the required uses and approved users of the data in the NPS. I will say a little bit more about that later on.

Slide 13

CMS will be awarding a contract for the Enumerator. There will be only one Enumerator, which we had called the registry in the proposed rule. The Enumerator will actually operate the NPS and will have access to all the data that is in it. It will help providers with their applications and their updates and will answer their questions and resolve any problems. They will also process requests for information from the NPS. We will have to follow what is in that System of Records Notice and any other established laws and regulations concerning data release.

Slide 14

Existing providers will obviously have to obtain their NPIs. I know there has been talk around about how we will automatically enumerate Medicare providers. I know in the proposed rule we mention that, and in the Final Rule we said we were studying the feasibility of it, and if it is feasible, we will do so. That is still the case, although I do believe these would just be the individuals who have UPINs. They would not be the institutional Medicare providers, probably not the suppliers either. We have not made a final decision on that yet, but if we do, these providers will receive notification that they are automatically going to receive their NPIs. They won't have to apply for them. That information will most likely come to them from the Medicare carriers, because these are Medicare providers. Providers should take no action at this time to apply for NPIs, because the capability does not yet exist. We will be putting information on the CMS HIPAA website, which is the one that the Office of HIPAA Standards maintains, with respect to applying for NPIs, but we will be doing this closer to the May 2005 date. We expect very heavy traffic on the NPS and a lot of activity at the Enumerator when the effective date arrives, because all the existing providers will be able to begin applying for the NPIs. The health plans and others out there in the healthcare industry will want to know which NPI has been assigned to their various providers.

Slide 15

As I mentioned before, non-covered providers are eligible for NPIs, but they are not required by this regulation to obtain or use them. We can only place requirement on covered entities. We do encourage non-covered providers to apply for and use NPIs, and of course, we encourage them to comply with all the other requirements we place on providers who are covered entities. There is nothing in the Final Rule that prohibits a health plan from requiring its enrolled healthcare providers to obtain and use NPIs as long as those enrolled providers are eligible for NPIs as explained in the Final Rule.

Slide 16

We will have three levels of users of the database of the data house in the NPS. Level 1 users are the Department of Health and Human Services, which includes CMS and the Enumerator. They will have access to all the data. Level 2 users include members of the healthcare industry, such as health plans and clearinghouses, who will need NPS data to match providers in the NPS to providers in their files. In order to do this, health plans might need certain Privacy Act protected data, like somebody's date of birth, about enumerated individuals. This information would be released only upon approved requests. The System of Records Notice describes the routine uses and users of the NPS data. Routine users do include health plans and anyone else who needs NPIs in order to conduct a standard electronic transaction, because that is a legal requirement. Level 3 users are members of the public, and they would not have access to any data that is protected by the Privacy Act. There are several complex issues involved in the release of data from the system primarily because it does include individually identifiable data. We have to be able to make the data available to the routine users for the uses listed in the System of Records Notice. We have to access fees for the release of data, if it is appropriate, and we have to establish a fee structure to do so. We have to follow all of the applicable laws and regulations with respect to protecting data and to releasing data. We will be publishing at a future date in the Federal Register a notice that will explain in a little more detail our data dissemination strategy. That is not going to be something for comment; that is just going to be a notice.

Slide 17

These next few slides contain a summary of what the Final Rule actually does. I hope it is not to boring if I go over this. It does define a covered health care provider. Someone could figure that out from the covered entity definition, but we decided that it might be a good idea to put something in here since this rule does relate to covered healthcare providers. The Final Rule sets the compliance dates, it announces the standard and its required and permitted uses, it lists the functions of the NPS, and it states the requirements for covered entities.

Slide 18

I talked a little bit about what covered providers have to do. Covered providers also have to disclose their NPIs when someone requests it, if that requestor needs it to complete a standard transaction. Somebody could go to a covered provider and ask them for their NPI, and they would have to disclose it. Covered providers have to furnish updates to the NPS of any data that they put on their application within 30 days of the change; if they have a new address, a different or additional Taxonomy Code or if any of that information changes, they are required to report it on the same form as the application back to the NPS. That form will serve dual purposes. Covered providers have to require any business associates that they might use, such as a billing service, to use NPIs appropriately on the transactions that they prepare for that covered provider. A covered provider has to comply with the Final Rule requirements for any NPIs that have been assigned to any of its subparts. Obviously, that just applies to organization providers.

Slide 19

The other covered entities, which are the health plans and the healthcare clearinghouses, are required to use NPIs appropriately in the standard transaction. Health plans cannot require a provider who already has an NPI to obtain an additional NPI.

Slide 20

We have all probably read the Final Rule, and it is too early to begin applying for NPIs so what should covered entities be doing right now? They should all be aware that we did adopt the NPI, and the reason that we adopted it. They should know that all healthcare providers are eligible for NPIs. They should visit the CMS HIPAA website, because we do have a direct link to the Final Rule. We have the check-digit algorithm on there. We do have at least 16 questions and answers relating to the NPI. You will have to key in NPI to that little search block, if you want to just pull up those questions that have NPI in them. There are 2 more questions that should be posted very soon. Covered entities need to look at the functions they perform to see which ones are affected by the NPI and how. If there are going to be problems, they should be able to identify them sooner rather than later, and begin figuring out how to resolve them. Covered entities should be talking to their trading partners to develop and discuss plans for implementing the NPI such as are they going to do everybody at once, are they going to stagger the dates that they will want compliance. The compliance date is really the drop-dead date. A health plans, for example, could require its providers to use NPIs prior to the compliance date. All covered entities should take measures to educate their staff about the NPI and its implementation. It is probably these people who will be filling out the applications, and they are the ones that we will call or the Enumerator will call when they have questions about information on the applications.

Slide 21

The overall effect of the NPI on all covered entities will be positive. Although, some of them will have more work to do than others to implement it, and some may have to wait longer to see the benefits. Providers will need to use only one number, their NPI, no matter which health plan is being billed and regardless of where or under what circumstances the services are being provided. This will simplify providers billing processes and will reduce the amount of information they may have to keep track of with respect to other providers identification numbers. For example, people that have to have ordering and referring information for the provider for whom they work; they wouldn't have to keep track of multiple numbers for them. Because the provider will be identified only by its NPI, the coordination of benefits transactions should operate more smoothly, and providers should be able to get their payments sooner.

Slice 22

The NPI will have a major effect on health plans, and most of them will have a lot of work to do to implement the NPI. The fact that any provider or subpart who has been assigned an NPI will be using just that number in standard transactions is something that may require many changes to a health plans process. As we all know, health plans have gotten accustomed to assigning their own identifiers to providers to represent all sorts of arrangements for all sorts of reasons. They also included intelligence sometimes in a lot of those numbers. Now they are just going to have to make do with one number with no intelligence.

Slide 23

Health plan will be able to do away with some of the numbering systems that they currently maintain, if they wish. For example, in the Medicare program, somebody in Medicare will be deciding the fate of the UPIN on how long will they continue to be assigned. They won't be able to be used in standard transactions after the compliance date, but Medicare may still use them in some sort of internal process some place. One of the benefits down the road for health plans is simplified coordination of benefits, obviously because the provider is identified with just a single

number. A health plans utilization review and program integrity systems should be more valuable because providers will only have one number that needs to be tracked.

Slide 24

The Final Rule does not effect health plans internal processes or any transactions that aren't standard transactions, at least not according to what we say. It is up to the health plans as to how far they go in making changes to replace existing provider identifiers with NPIs within those systems. For example, health plans probably conduct various provider surveys and might collect cultch reports. Whether or not the NPI will be used to identify providers in those activities and replacing the identifiers currently used is up to the health plans. Health plans must consider the impact of the NPI on the data that they all ready have on hand. Will they want to associate NPIs with those data? Will they want to establish links to NPIs, and reports and statistics that contain legacy identifiers? Will they want to replace them with NPIs? Will health plans need crosswalks to NPIs from various legacy identifiers? We do expect that the NPS will produce reports containing providers NPIs and the other provider identifiers that can be associated with that provider, but of course, all this information is only going to be as good as what the providers furnish on that application. We can't require them to furnish other identifiers, because we would not know whether they had any other identifiers. We could say it is required, but if they left it blank, we would not be able to prove that they had a number and just chose not to report it.

Slide 25

One activity that health plans will not be discontinuing when the NPI is implemented is their provider enrollment process. I have spoken with people who seem to think that getting an NPI completely eliminates the fact that they would have to enroll in a health plan. Health plans will have to continue this process and will continue to validate the information they collect as part of that process. This does involve a lot more data collection and a lot more data validation than does the NPI enumeration process. Memberships and groups, contractual arrangements, and multiple practice locations will not be part of the NPS. They are not needed to uniquely identify providers. If health plans want this information, they will have to continue to collect and maintain it. Health plans will need to work with providers and other trading partners to coordinate NPI implementation dates.

Slide 26

The effect of the NPI on healthcare clearinghouses is very similar to its effect on health plans. However, because many clearinghouses deal with many providers and many health plans, clearinghouses would probably have to spend more time acquiring providers NPIs than would health plans and less time in incorporating NPIs into activities that are not standard transactions that they may want to incorporate the NPI into. The coordination of the implementation date with trading partners will need to be done.

Slide 27

The NPI will be used as the provider's primary and only identifier. The legacy identifiers (Secondary Identifiers) will not be used after 5/23/07 to identify providers who have NPIs. The EIN, which is issued by the IRS, may be used, for tax purposes, per the Implementation Guides (Pay-to, Billing Providers). The Final Rule does not require the NPI to replace the ETINs.

Slide 28

In an effort to educate the industry, we ask that you check the CMS HIPAA website (www.cms.hhs.gove/hipaa/hipaa2). It provides a variety of helpful information such as analysis of public comments, a link to the Final Rule, an overview of the Final Rule, FAQs and the check-digit algorithm. We will be working to help guide you through the implementation of the NPI and will continue to provide outreach activities. We will respond to any questions that we receive. There is a Hotline available at 1-866-282-8659.

Q: When will an authorized user be able to request information for the NPS?
A: Not until after the implementation date of 5/23/05.

Q: Implementation Guides will need to be revised. How will that happen?
A: The revisions to the Implementation Guides are currently being worked on. I do not know the timetable for that. I believe that they are all finished modifying the 4010.

Q: The discussion on the subparts within an organization, how are you going to marry them?
A: We do not feel that it is necessary. The NPS system is not going to care about the subparts. The issue becomes an issue someone files a complaint.

Q: What is the recourse if the provider does not update their information within the 30 days?
A: They will be in violation.

Q: The reason I ask that question is if there is to be a file available to the state system, how would they do that match?
A: The way we envision it they could communicate using their other data. We do not see it as forever more the NPS telling the industry. I am not saying we want our data to be bad, we want it to be excellent.

Q: Has an Enumerator been identified?
A: No, the RFP will be going out in the next two months.

Q: Can a payer require a non-covered provider to get an NPI even though they are non-covered?
A: Yes.

Q: Taxi services are not required to get an NPI?
A: They are not a healthcare provider. A taxi service would not be given an NPI.

Q: Say for whatever reason a big hospital wants only 1 NPI, even though they have a variety of different areas within that hospital. If they say no, is that the end?
A: Yes.

Q: Are there any additional ways to get information to providers?
A: Basically the main vein is the CMS HIPAA website. There are open door sessions with Medicare. There is not much information to put out there right now except the summaries of the Final Rule, etc. If you have any good ideas on ways to get the word out, please let us know.

Q: Because of the language in the Final Rule, there is now language in the Implementation Guides that is now incorrect. How will the correct information be made available?
A: There are FAQs on the CMS HIPAA website that will explain. For the mechanics on whether we will adopt some future versions or just guidance, refer to the FAQs.

Q: Say we have got a certified or contracted provider with a Medicaid ID they are using to identify on claims, and then they register for an NPI. Then that NPI starts showing up on claims, they start pending, and the provider starts complaining. What are his requirements to let us know that he has registered and received an NPI?

A: They are required to inform the health plan.

Q: In this situation, would it be good for the health plan to put together a policy?
A: The health plan can require it.

Q: Can other ID numbers be used through May 2007 even if they have an NPI?
A: Yes, they could do anything until the compliance date.

Q: Would we be able to get into the NPS as a health plan or agency?
A: I don't think you will be able to do anything but access your own data.

Q: Diane Sanders - If we had access to the NPS, we would not have to worry about someone getting an NPI and not telling us. Could we get access to the subset of the information?
A: There are security issue rules we have to follow. We do need to respond to the needs of the industry. We are in the middle.

Health Plan - Plans have a single provider out there with many IDs right now.
Pat Payton – Some of the information will be shared for that very purpose.

Q: When you say share, can the health plans get batch information?
A: Yes, but it would have to be one at a time.

MaryKay McDaniel – I would suggest that we use the SNIP workgroup for this information. I have information to get to you.

Action Item: MaryKay McDaniel
Get health plans the information to join the SNIP workgroup.

Q: Can an individual have more than one NPI?
A: No, he would be assigned an NPI, and he would use it to identify himself where ever he needs to be identified. The group practice would have his NPI, maybe it would be the billing provider or whatever, and the hospital would have its NPI, but no, he couldn't have an NPI to use when he is doing this at the hospital on Mondays, and then when he is over at the Main Street clinic on Fridays, he uses a different number. We would be right back to where we are now with more than one NPI per provider. That is one of the issues that I know they will be talking about in the WEDI SNIP group, because I know that Peter Barry and I have talked about that problem.

Q: Back to the requiring the subparts. If the hospital has an NPI, but the lab is also doing some stuff, but reporting it under the hospitals NPI, can we go back and request that lab and subpart get their own NPI?
A: You could ask the hospital to have them do it, but the hospital would be the one that has to make that decisions. I would think that they would want to have their subparts enumerated, but then I am not really there.

MaryKay McDaniel – I think that it is going to depend on what the payment arrangement for them will be.

Pat Payton – I would imagine it will. For Medicare providers, which of course are the ones that we know the most about. We would think that just about any entity that has a Medicare provider number, we're talking not multiple numbers now, would be able to have an NPI, but with the subpart concept. If the covered entity says so. They are using these numbers now to bill Medicare, labs and whatever, so we would imagine that they would probably want them to have NPIs.

Q: A couple of questions based on what is in the Final Rule. Has there been any changes to the estimated cost savings from this implementation?

A: In reference to the Final Rule, those are our final impact analysis figures. The only thing that anybody can comment on the way the Final Rule reads is on how long it takes to fill out the application form, and how long it takes to fill out that form to provide updates.

Q: And the second part of that is, do we still think that this enumerating system is going to last 200 years?
A: Yes, we still think that NPIs can be assigned for 200 years at the current rate of provider growth.

MaryKay McDaniel – Pat, thank you very much. In case anybody wants the website for WEDI SNIP, it would be http://wedi.org/snip/, and underneath there, it says very clearly, **Workgroups and Listservs**. Under **Listservs**, it goes for about two pages, and it would be the **WEDI SNIP NPI Subworkgroup List**. The first meeting was Monday; they are going to be meeting every other week at 1:30 Arizona time. Peter Barry is going to get the actual information out on the Listserv. It really was an exceptional conference call. As far as the versioning, I know that there are two sessions of X12 in June specifically geared towards the Implementation Guide updates.

Q: What about the 4010 A1? If they come out with another guide, the guide takes 26 months to become law.
A: They are not sure on that. They are waiting for the wiggle room on that. That is currently with their attorneys for review. It does not change the format in their minds. Like going from an ICD 9 to an ICD 10 where you went from 5 digits to 7 digits, and the entire way you use it is different. In their minds, it is just like a code set, when somebody puts out new code sets. We accept new code sets at quarterly changes, annual changes. What their thinking was is that a new version of something that didn't radically change the structure and format would not be the 26 months.

Lori Petre – I wanted to make sure that everyone saw the sign-in sheet outside, and that everyone signs in. If you didn't do so on your way in, please do so on your way out. Poor Mel was having a problem getting those back. We try to account for everyone who was present in the minutes, and because we weren't getting those back, we were not always able to do so. The sign-in sheet will now always be placed outside the door. We will put NPI on the agenda in the future, and we will try to let you know ahead of time. We are actually trying to gear up internally on how we are going to handle it. We will be sharing those things with you, and it will be an ongoing conversation item in this meeting as more information becomes available.

3. Follow-up Outpatient Hospital Payment Fee Schedule (Lori Petre)

Directly following this meeting there will be the first Outpatient Workgroup for those of you who did respond back to the survey and provided names. All of those folks should have received emails, I believe I sent it out to our key contacts, that the meeting was going to be occurring. Sara Harper will talk a little bit more about how that is going to work, but we will probably have those meetings every time we have a Consortium meeting. Sometimes they may precede the meetings; ideally, we would like to do that so that we do not have to keep you here so late. Unfortunately, someone else had this room immediately preceding this meeting, and we were not able to do so today. As far as an update on that, we are going to walk through the timeline that has been established for how we are going to handle it, a flowchart that we put together, and also, we are going to share with you a draft of our System Requirements document for our Provider, Reference, Claims and Encounters systems. Even if you weren't somebody that said they wanted to attend this workgroup meeting, everyone is invited to stay for that immediately following this one. The other update that Sara wanted me to share with you is the single sheet that I passed around. Sorry, I received these 10 minutes prior to the meeting so it did not make it into the package. It is a memo that went to the CEO's, and this is the current status on the Fee Schedule Update. Sara wanted to make sure that you got this update like she promised. We will try as much as possible to share with you anything that has gone out to the CEO's.

4. Daily Co-Pays/BBA Data Certification (Dennis Koch)

Daily Co-Pays

We are still testing co-pays, but as of today, we got an injunction to stop mandatory co-pays. We modified our system so we will no longer create mandatory co-pays. We are looking into how to convert everyone that is mandatory to an optional. We will try to get you the information as soon as possible, but you are going to see a little spike in your 834s or rosters when we do that. Just be aware of it. We have sent out letters to the members, we send out letters to the providers, and you will probably get a formal letter from us to the health plans, also. We are still targeting 5/1/04. It does not effect our daily process.

Lori Petre – Dan Lippert was at a meeting on this with the Director's office. There is a letter going out to the CEO's today. We will get a copy of that to you after this meeting just as soon as we can get to it.

Action Item: Lori Petre
Send copy of the CEO Co-Pay letter to health plans.

Q: When is the injunction effective?
A: We are not sure when it will be effective. We are working on a conversion program right now. We are not sure if it is going to be effective 5/1/04 or 4/1/04 as it might be retroactive. You will see a full co-pay change at that point.

Lori Petre – That was the meeting that they went to was to walk through what would be the effective dates, what would need to be done immediately, etc.

Q: Are you saying that the eligibility file will be affected tomorrow?
A: No, you won't see anymore mandatory co-pays for tomorrow. We are thinking in the next day or two you will see where we convert all the mandatory co-pays to optional.

Q: For our claims adjudication system, we told AHCCCS that we would go ahead and take the mandatory co-pays off the top. Should we stop that date of service of today?
A: Lori Petre – It may actually go retroactively from what I understand about the injunction. Why don't you wait to see what we find out. Again, if I can get something from them this afternoon, I will send it out to you before I leave today.

BBA Data Certification

We are still shooting for 5/6/04. There is a little confusion on the proprietary files and pend corrections. Basically we are looking for the count and dollar amount that is on your T9 record; that should make it real easy. Whether it is a FA, FB, FD or your pend correction file for the proprietary side. Pull every dollar amount and count in there, and that should certify the file.

Q: On the pend correction file, we should identify the record count not the claim count?
A: Right, what the process does is look for the T9, then pulls the count and the dollar amount.

Q: So all the proprietary files, FA, FB, FD, etc., pull the information from the T9 record?
A: That is correct.

Action Item: Dennis/Lori
Send an email to health plans regarding the exact information.

Q: On the X12 837 it is the number of CLM segments?
A: Yes.

Q: Would that be the 2nd CLM segment?
A: Yes, CLM02.

We had a transmission problem over the weekend that only affected files at zero length records, with no records in them. When I sent out a broadcast, I got some emails back. I am not sure if everyone gets those emails. If you want to get an email, send a note to the AHCCCS HIPAA Workgroup requesting that you be added to that notification. Usually the notifications are for when the 834s or late or we are having an issue with the 820s.

Lori Petre: They are using the long standing production list for those.

Q: How many plans are testing with AHCCCS right now.
A: Brent Ratterree – There could be eight. These are counted by health plan ID.

Lori Petre – You will find a handout in your packet, Chapter Two Encounter Authorizations & Control Documents, that is in response to an action item from the last meeting regarding clarification of the BBA language.

5. Encounters 837/277U

Testing Status

Some of you have seen this document. I apologize, as I did not get this emailed until around lunchtime for the majority of you. You have this in an email that went out to the entire Consortium group, but I also wanted to make sue you had it here. Basically what this says is that we had an internal on Monday with the technical teams, mostly Mike and Dennis and their staff. We assessed where we thought we were still having problems. To be absolutely frank, I don't think that our 837 testing process went at all the way that we would have liked to have seen it. I don't think that any of us feel that we are currently at the point where we wouldn't be at risk to implement it. We documented where we had outstanding issues, and then Dan and I met with Brent yesterday, because he is our primary customer for this set of transactions. We are the service bureau so we did not want to make decisions about whether to implement or not. It is our place to make sure that our customers have the information available to them to make that assessment. Yesterday afternoon Dan and I met with our Director, Jim Wang, and he subsequently talked to Kari Price, who Brent had already briefed on this, and they made a collective decision, if we implemented at this time we would be putting out a product where the risk out weighed the benefit. We did make a decision to delay the encounter implementation until the June cycle; we were going to go for the May cycle. We have two significant issues plus a lot of little things that were getting through. Probably our most significant issue right now, and it is one that is completely out of our control, has to do with our translator. Our translator currently cannot process files above about 50,000 encounters. Dennis and Dan have worked with Mercator. It is in their engineering department. They are assuring us they will come to us with a solution. The translator is a pretty significant issue; we need them to comply with the contract, which says they will support our necessary data volumes. We also know, because of some of these efficiency issues, if we were to push it through or workaround this, it would take forever to run on the Connect Direct side. We are working on that also. Second major issue is that when we looked at the testing that had occurred, there are a couple things that we are concerned about. We have not, with our trading partners, tested the full process in a lot of cases. There are several reasons for that. We know that with the issues that we had with BBA three weeks ago, and then the necessity to refresh the bases as a result, a lot of the full cycle testing through

pends and adjudicated encounters could no occur. We have not processed an external pend correction file on the new data. We make all kinds of them up ourselves, but we can't suppose what your processing environments look like and what kind of unique records and changes you are going to want to make. We didn't feel that the entire process had been tested as thoroughly as we would have liked to have seen. The majority of test cases we are seeing are very, very nice vanilla claims that are going to go through without any problems. We have identified a lot of issues, and we are working right now on documenting those. We will share that documentation once it is completed.

Action Item: Lori Petre
Send health plans documented issues.

We are going to step up our resources; we have made it very clear to our staff that this is the last move on this implementation date. We do apologize for the late notice and for the need to move this up. We try to set a standard where we do not roll out products that we know are not going work. What we need you to do in the mean time is keep testing. Send us complicated files, and don't hold back on the volume. Test your outbound, 277U, and Supplemental files. Make sure what we are giving you back is what you expect and that you can use it. Continue to test the pend corrections files that we send back to you, and continue to send some back to us.

Contingency Planning

Attached to the email was a revised Milestone chart where I tried to clarify some of the other things that were a little confusing. One of those is contingency plans; contingency plans technically are not required right now, because you are not required to be compliant until 7/1/04 dates of service. We will be contacting all of you to obtain a target date for implementation for monitoring purposes. I changed the final companion document date, as it cannot be finished until we go into production. I revised the dates for ongoing testing, and then put in a separate window for contingency testing. I indicated a system implementation as opposed to those dates with which you were required to comply. If you do have questions about that, let me know. If you have suggestions or see anything coming back to you or not coming back, let us know right away. With the change we have made to route the issues through Marsha prior to going to Dennis' team, that Marsha is staying on top of those pretty well.

Dennis Koch – Sometimes there is a little confusion on what is ready when, where, and how. When you submit a file to the FTP server, Mercator sweeps the FTP server every half hour starting from 8:00 a.m. to about 6:00 p.m. When you drop the file, it will sit there for about 30 minutes max, and the file will be gone. You can send in your email to certify that file anytime. We check the email every minute. You will not get a response back until that file has been pulled. If you drop a file and send an email, you are not going to get a response back until a half hour after we have pulled the file and bring it in for processing. Once the file has been certified, it then goes into our certification process that will check to see whether or not the file is certified. At that point, you should get your acknowledgement. From there, it sits and waits until 5:00 a.m. to be loaded to the mainframe. If you send in a file this afternoon, certify it, it gets processed, you get your acknowledgement, but it won't get loaded to the mainframe until the next morning at 5:00 a.m. Tuesday nights and Thursday nights are when we run the so-called monthly process; we run any file that has been loaded at that time. If you put a file in Tuesday afternoon, you are going to miss the cycle, because it won't get loaded until Wednesday morning. On Wednesday and Friday you should see your 277U, pend files and everything else out on the server that morning. The process is a little bit more complex than it used to be.

Brent Ratterree – I am working on the revised version of the companion document to label some required fields. They will be very simple examples. They will have some COB information, but will not include anything complex such as transplants, etc. I hope to have it by the 5/12/04 Consortium meeting.

Action Item: Brent Ratterree
Have updates to the 837 Encounter Companion Document by the 5/12/04 Consortium meeting.

6. Encounters NCPDP (Brent Ratterree

Lori Petre – On 3/12/04, I sent out the most recent layout that I had receive. I did not mark that draft, and I do apologize. Please be aware that it is a draft document so it is open to comments and questions. If anyone did not get that and needs it, please let me know.

Brent Ratterree – I know that there have been a couple of questions that have come through, and we have responded to those questions.

Q: On the field IDs, we were wondering where you got them? We do not find them in the 3.2. For example, on page 6, there is a field called B40-17; I do not find that anywhere in the 3.2. And you have those fields in the prior page 5 that you are addressing as N/A.
A: The field IDs that you that you see listed are from the 5.1 beginning at PBM supporting information. This is simply to help you take what would be processed on the 5.1 and where you could map that to on this transaction. That is where the field IDs are coming from. The stuff that is listed as N/A is not in the Implementation Guide; it is something very specific for AHCCCS, and that is what makes a modified 3.2 version.

Health Plan – What would really help in this, granted that it is not one-to-one mapping by any means, but to truly call it map, which goes from one destination to another, would be to add another column where you might put what used to be the proprietary format, and what field that correlates to.
Brent Ratterree – We can put something in here for that, but you will not see one-to-one correlations.

Action Item: Brent Ratterree
Add another column to the NCPDP 3.2 layout to show proprietary format.

Q: You did this for the 837; can't you do it for the NCPDP?
A: The unfortunate thing with the pharmacy is that some of these fields are not on-to-one. For example, the payment fields. They are listed as just payment, and that is the way that they are listed in the 5.1; various different payments. Because of some other qualifiers that relates to the field, it makes it different.

Q: What about some examples? How soon can we see something like that? Even some examples of what you are kind of going towards would be helpful.
A: We can work on something.

Action Item: Brent Ratterree
Prepare and distribute NCPDP 3.2 examples.

Q: Is the NCPDP 3.2 still on schedule for July 2004?
A: Lori Petre – It is a separate development team.

Q: Will you be using Mercator?
A: Lori Petre – We are not translating the NCPDP file. That was part of why we were not able to go within the timeframe of the 5.1. The translators do not have type trays for the NCPDP format.

Q: On the SVB, a field that deals with the Header, we have a field called an 880-K4 text indicator. What is that?
A: I would have to refer you to the Implementation Guide.

Lori Petre – We will take that as a question, and get back to you.

Action Item: Brent Ratterree
Let the health plans know what this field means.

Health Plan – At the next Consortium meeting, it would be helpful to have whoever wrote this available to answer questions.
Lori Petre – That reference in which respect?
Health Plan – So if we have questions, instead of us waiting another few weeks for an answer or having somebody standing up and saying 'we have to refer you to the implementation guide'. The person that did this with the knowledge could answer right then giving immediate feedback and interchange of information so we both can go towards that common goal.
Brent Ratterree – Actually, I did this.
Lori Petre – The programmers basically just formatted based on the requirements that they were getting from Brent.
Health Plan – Okay, I guess we need that programmer then.
Lori Petre – Do you think that Mark could speak to this more than you could, Mike? All he was doing was very much reacting to what the requirements were.
Mike Upchurch – Now the header and trailer, that is probably something that I can address with Brian, because that was standard format.
Brent Ratterree – That is the batch 1 header and trailer. There is a field listed in here listed as text indicator, but there was nothing identified in that field.
Health Plan – So what I am gathering is we don't really yet have an NCPDP guru to speak of. That is the feeling that I am getting here.
Lori Petre – The requirements for the format were very much dictated by Brent's team. The programming staff were assigned to respond to those requirements.
Health Plan – I am not trying to come down on AHCCCS, because I realize that somebody up above made this decision and told you to make this work. We are on the receiving end trying to make this work, and there is some frustration for us as well.
Mike Upchurch – We can address the questions as they come to us and get you answers without you waiting three weeks to get them. If you will address your questions to the AHCCCS HIPAA Workgroup, then within 24 hours I will have an answer for you.
Health Plan – Perhaps it would be worth while for us to have some working sessions.
Lori Petre – Yes, it is sounding like we need to do that. We were not sure that you had an opportunity to review the layout and whether you had questions. We can certainly schedule a separate session.

Q: Would it be beneficial if these questions were answered and posted to the entire group?
A: Lori Petre - Yes.

Q: Do you know when you will be ready to test?
A: Lori Petre - It is actually in the Milestone Schedule that was attached to the email that was sent out. Trading Partner testing is scheduled to begin 5/10/04. That would be the earliest date that we currently anticipate it. If it were to come early, we will let you know.

Lori Petre – We will schedule a separate workgroup for the NCPDP, and I will try to do that as soon as possible within the next week or so. In the meantime, we will work on that crosswalk back to the proprietary, and have you some examples for that discussion.

Action Item: Lori Petre
Schedule a special Pharmacy NCPDP 3.2 session.

7. Wrap-Up (Lori Petre)

The next meeting is currently scheduled for Wednesday, 5/12/04. If you have agenda items that you would like to see, do let us know. It sounds like we will have at least a meeting on NCPDP

available to you in between. If you want to stay for the Outpatient Workgroup meeting, it will be here starting right at 4:00 p.m. Please feel free to attend.

Meeting adjourned.